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C&D

29 June 2002

First repeat dispensing by the autumn

YPG expands on details for Society reform

Wholesalers: we can't run free services

Time to unlock the lucrative drugs code

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1st proxy form.

Must be received by 3rd July. (Latest.)

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The Directors of Numark Limited consider the conversion and the offer for subscription to be in the best interests of Numark Limited and its shareholders as a whole.

Don't forget, your vote is important and affects the future of Numark Limited, so let your voice be heard.

If you have any queries, call Stephen Marks on 01827 841200 or Jonathan Cable on 020 7626 3322.

NUMARK PHARMACISTS
PUTTING YOUR HEALTH FIRST

Published Saturdays by
CMP Information Ltd,
Sovereign Way, Tonbridge,
Kent TN9 1RW

C&D on the internet at:
http://www.dotpharmacy.com/

Subscriptions: (Home) £150 per annum;
(Overseas & Eire) $369 per annum including postage, £2.60 per copy (postage extra)
Additional Price List: £100 per annum

Circulation and subscription:
CMP Information Ltd, Tower House, Sovereign Park, Lathkill St, Market Harborough, Leics. LE16 9EF
Telephone: 01858 438809
Fax: 01858 434958

Refunds on cancelled subscriptions will only be provided at the publisher's discretion, unless specifically guaranteed within the terms of subscription offer

The editorial photos used are courtesy of the suppliers whose products they feature.

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C&D

Chemist & Druggist
The Newsweekly for Pharmacy

Volume 257 No 6348
142nd year of publication
ISSN 0009-3033

This week

Regulars

Pharmacy update

Features

PRESCRIBING

Repeat dispensing to start in the autumn

Community pharmacists may be dispensing NHS repeat prescriptions as part of a Government pilot scheme from the autumn.

Primary care trusts will be invited to apply to be "pathfinder" sites by the end of July, depending on changes to GPs' computer software and legislative requirements.

The scheme will be limited to 30 sites initially and will only include GP prescribers and pharmacy dispensing contractors. It will be up to the PCT to decide how many practitioners are involved.

Repeat dispensing will be voluntary and GPs and patients will be able to choose between acute prescriptions, repeat prescriptions as they are generated now, or the new scheme.

The DoH anticipates that the scheme will only be used for patients with stable, chronic conditions and not exclude any drugs other than controlled drugs in Schedules 2 or 3.

Remuneration for pharmacists has yet to be finalised but the guidance says "the standard dispensing fee will be paid when an item is dispensed and in addition a monthly or annual payment will be made to cover the occasions when a prescription is not dispensed, and the other requirements of the service".

Other requirements of the service for pharmacists include:

- extra professional responsibility involved with dispensing discretions
- longer patient consultations
- staff training
- patient and staff initiation with the service
- liasing with prescribers
- storing prescriptions and, at the request of a patient, batch issues
- submitting finished or expired prescriptions to the prescription pricing authority.

Pharmacists will not be entitled to change the frequency, formulation, chemical entity or dosage but, if legislative changes are made, will be allowed dispensing discretions in two areas. These would be:

- supply of a smaller quantity than that prescribed if the patient already has some of the medication
- dose optimisation, eg allowing the dispensing of one 20mg tablet rather than two 10mg tablets where there is no clinical reason not to do so.

Sue Sharpe, chief executive of the Pharmaceutical Services Negotiating Committee, said the structure of the scheme was how it had been envisaged but many areas needed clarification.

"We need to understand more clearly the standards and expectations so that pharmacists understand what is a discretion and what is a duty," she said.

A second wave of the scheme is expected next July. Depending on the outcome of the pathfinder sites the scheme is due to be rolled out nationally in 2004 as announced in the NHS Plan.

- Repeat dispensing was one of the methods announced by the Cabinet Office this week for reducing the burden on GPs. Other recommendations in the Regulatory Impact Unit's report include the extension of prescribing responsibilities, supply of gluten-free foods without GP input and medicines management.

A target of August has been set for the establishment of a significant issues group on medicines management and prescribing. It will support PCTs and comprise representatives of all stakeholder groups.

How will it all work?

Only GPs using computer-generated prescriptions who are not involved in the electronic transfer of prescription (ETP) pilot sites will be able to be part of the trial.

Patients will receive the original prescription signed by the prescriber and an additional set of prescriptions which will be used for dispensing and reimbursement.

The pharmacist will retain the original prescription and the patient may ask the pharmacist to store the additional copies.

Patients will be limited to one pharmacy and if they wish to move during the scheme will be required to obtain another prescription from the doctor.

The prescription will contain all the usual details but the prescriber will be required to specify the number of issues from the original prescription and the dispensing interval.

A prescription charge will be payable for each issue.

For more information:

www.doh.gov.uk/nhsrepeatdispensing

E-mail: *susan.grieve@doh.gsi.gov.uk*

Bradford School of Pharmacy has instituted an open day for parents of students approaching the end of their second year. They met with staff and students, toured the research laboratories and saw practicals in full flow. Simon Tweddell, head of external relations, commented: "We are conscious that the only time we meet the parents of our students is at interview before students commence their studies and then again five years later at graduation. By inviting parents of students approaching the end of their second year, we hoped to increase involvement and respond to any issues"

US omeprazole goes OTC

Omeprazole may be available over the counter in the USA if the Food and Drug Administration follows the recommendation of its advisory panel.

They voted 16 to two to support an OTC switch of Prilosec. Procter & Gamble will be responsible for the marketing of the OTC product which would be probably have a once-daily, 14-day dosing schedule.

As there is no P category of medicines in the USA consumers would be able to self-select prescription strength omeprazole.

POLICY

Meeting to discuss SOPs

The Royal Pharmaceutical Society is hosting a meeting on Monday (July 1) to discuss standard operating procedures (SOPs) for dispensing.

The Society has launched guidance to pharmacists on how to develop SOPs, which must be in place by January 1, 2005.

The proposals and their implications will be discussed by industry representatives.

Pharmacist Jeremy Armes, who in his other life is a pharmacy buyer for Asda, has just returned from a six-month sabbatical trekking through the Himalayas. Two weeks were spent trekking from Lukla at 9,800 feet, to Kala Pattar (18,194ft) above the Everest base camp where he is pictured. "I've always wanted to travel and finishing this trek required a lot of willpower. Seeing Everest was a dream realised," he said. But wasn't he cold in just a T-shirt?

PROFESSION

YPG reveals Society plans

The Young Pharmacists' Group has described in more detail its plans for how the Royal Pharmaceutical Society can modernise its regulatory and representational roles.

Its main proposal is the establishment of a "Pharmacy Regulation Compliance Committee" which would look after the Society's regulatory processes. Other proposed changes include:

- the president should be directly elected by the membership for a three-year term
- the Society's secretary should be a member who is appointed annually by Council
- a registrar, who cannot be the same person as the secretary, be appointed to look after the PRCC
- members could only serve a maximum of three terms of three years in the Council, PRCC, Statutory and Audit Committees.

The PRCC would enable the Society to comply with statutory requirements as well as help conform to the recommendations of the Kennedy Report, which has called for more stringent practices in professional self-regulation. It would report to the Society's Council, and have the Statutory Committee report to it.

Among its main functions, the PRCC could be responsible for:

- appointing the Society's registrar
- registering pharmacists and pharmacies
- approving profcssional rules
- ensuring compliance with professional rules and standards
- referring breaches of professional rules to the Statutory Committee
- policing law and ethics infringements
- fitness to practise
- pre-registration
- accreditation of the schools of pharmacy.

While the Society's oversceing Council would retain its current composition of 21 pharmacists and three Privy Council appointees, the PRCC would have the registrar acting as non-voting executive chairman, with the rest of the committee comprising eight pharmacists and seven lay members.

The Audit Committee with nine elected members and a chairman with appropriate auditing experience would "provide independent oversight of the financial controls, process controls and remuneration" of the various committees of the Society.

The YPG said that such changes would mean the modernised RPSGB is transformed into a chartered body and a modern regulator.

"The modernisation transformation laid out by the YPG will not require new legislation, or a change to the Royal Charter, as these changes could be achieved with alterations to the byelaws," it said on Tuesday.

"Therefore the modernisation could be implemented quickly. The recommendations of the Kennedy Report are also adhered to in this modernisation paper."

An article by Douglas Simpson reviewing the functions of the Society and how it may move with the times, appears on p28.

Northern Ireland fees go up

Pharmacist membership retention fees are increasing in Northern Ireland from July 1. The fees for full membership of the Pharmaceutical Society of Northern Ireland increase from £120 to £150; the fee for pre-registration students increases from £45 to £69; and the penalty for default in payment of the retention fee increases from £60 to £75.

For more information:

www.hmso.gov.uk

Pharmaceutical Society of Northern Ireland (General)(Amendment) Regulations (Northern Ireland) 2002. SR 206

DoH sets itself contraception target

The Department of Health has set itself a target of next year to publish good practice guidance on pharmacy availability of emergency hormonal contraception under a patient group direction. The target appears in *The National Strategy for Sexual Health and HIV – Implementation Action Plan* published last week.

For more information:

www.doh.gov.uk/sexualhealthandhiv

Hospital dispensing for the future

Hospital pharmacies could be able to dispense GP prescriptions in the future, health minister David Lammy has pointed out.

Last week, Bassetlaw MP John Mann asked what plans the health secretary had to allow hospital pharmacies to fulfil prescriptions from GPs.

Mr Lammy replied: "Hospital pharmacies could be providers of local pharmaceutical services under pilot schemes to be set up under the Health and Social Care Act 2001 and, as such, would be able to dispense prescriptions written by general practitioners."

Apply to be a third wave site

Up to 40 primary care trusts can apply to be a third wave site for the National Medicines Management Services Collaborative Programme beginning in October.

The National Prescribing Centre must have expressions of interest by July 26 and the final closing date is August 28.

For more information:

www.npc.co.uk/mms

E-mail: *npc-mms@liverpool-ha.nhs.uk*

MEDICINES

Manufacturers thank MCA for POM to P backing

OTC manufacturers have thanked the Medicines Control Agency for its work in developing the reclassification procedure.

At the Proprietary Association of Great Britain annual dinner last week, the president, Gavin Bell, said: "We are very pleased that moving more medicines from prescription control became a Government target in the NHS Plan and that the MCA took the lead in developing the work."

In particular, Mr Bell singled out the MCA's director of post-licensing, Dr June Raine. "In the past year she has become the champion of POM to P in both the UK and the EU."

Work that has gone on between the industry, professional bodies and the Government has produced a list of potential POM to P switches. "The list is an aspirational one and when it begins to become reality it will change the face of self medication," said Mr Bell. "The idea that people might manage their own insulin and cholesterol levels, treat their own asthma and manage chronic conditions might seem revolutionary now, but I suspect we will look back in a few years' time and wonder why it was such a surprise."

However, he warned of an area of concern: OTC branding. "At a cost of around £5 million and involving 10 years' work, developing a new brand for every new product is too expensive for a market as small as ours. Unless we can use new ingredients in established brands, the investment cost may be too high to make it worthwhile, and that means consumers will miss out.

"Without comprising consumer safety we have to be able to build on the trust and knowledge the consumer has in our established brands. We hope this guideline will build a common and transparent approach to this issue."

Two awards were presented at the PAGB dinner to the top candidates in the Association's professional learning programme and Diploma in OTC healthcare. From left: Johanna Kosanovic of GlaxoSmithKline, the PAGB's Sunayana Shah, and Fiona Hicks of Alan Hicks Associates

Surviving festivals

Hay fever sufferers are being advised how to survive festivals in fields this summer. The Consumer Health Information Centre's leaflet, *Hayfever – are you treating it right?* was launched at Glastonbury this week. It can be downloaded from the web and contains a simple "treatment tree" guide to symptoms and advice to "ask your pharmacist".

SCOTLAND

Scottish pharmacists warned not to be myopic

It is important not to have a short-sighted view of pharmacy practice, believes Alison Strath, retiring chairman of the Royal Pharmaceutical Society in Scotland's Executive.

"Although devolution is about Scottish solutions to Scottish problems, its pharmacists must recognise the challenges of being part of a GB-wide profession," she said.

The right medicine – a strategy for pharmaceutical care is a once in a lifetime opportunity for pharmacists to play a part in improving pharmaceutical care, she told the RPSiS annual meeting last week.

"Imagine *The right medicine* as a rope – it is there to pull us all up the hill. But it must not be used for a game of tug of war. It is very important that we continue to work together and not against each other to deliver its aim."

Ms Strath urged pharmacists to take part in the Society's modernisation debate. "We require a fundamental review of how the profession is represented and how the Society in Scotland operates. This will ensure that we are empowered to respond to the needs of our Scottish Parliament and its ministers in a way that represents the views of pharmacy practitioners working in Scotland."

- Scotland has seen an investment of £750,000 in community pharmacy premises as part of the Primary Care Modernisation Programme, and a commitment to develop the network as walk-in healthy living centres, Ms Strath told the meeting.

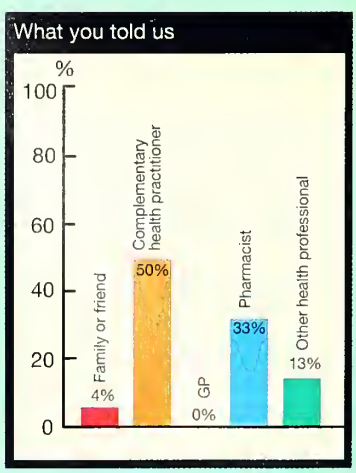
David Thomson takes the helm

David Thomson takes over from Alison Strath as chairman, Royal Pharmaceutical Society in Scotland's Executive.
Angela Timoney becomes vice-chairman.
Professor Christine Bond and Rose Marie Parr were also re-elected to the Executive. New faces are Professor Claire Mackie and Noel Wickes.

Questiontime

in association with UniChem

Last week we asked you: "Who do you think it is best for a member of the public to ask when first seeking advice about a complementary/alternative therapy?" You replied (see right):



This week's question: Which Prescription Only Medicine would you most like to see available over the counter?

- Naproxen
- Omeprazole
- Chloramphenicol
- Salbutamol
- Sildenafil
- Trimethoprim

You can record your vote on our website: *www.dotpharmacy.com* Question Time appears on the home page. Select your answer and then click on the "vote" box. Your answer is automatically collated. You have until noon on July 2 to cast your vote. We will publish the results in *C&D*, July 6.

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- National advertising campaign

Relieves everyday stress naturally

STRESSLESS Trademark and Product Licence held by Diomed Herbals, Hitchin, Herts, SG4 7QR, UK. Distributed by DDD Ltd, 94 Rickmansworth Road, Watford, Herts, WD18 7JJ, UK. **Directions:** To be taken by mouth. Adults and elderly: Two tablets three times a day. In severe cases three tablets three times a day for two weeks, then two tablets three times a day. Children 8-12: One tablet twice a day at the discretion of the practitioner. For smoking withdrawal: Three tablets three times a day. Do not exceed the stated dose. **Indications:** A herbal remedy traditionally used for stress and nervous tension associated with the changing demands of modern life. Also provides progressive relief of mild anxiety, and relieves nervous strain while giving up smoking. **Contra-indications:** Not to be used if sensitive to any of the ingredients. Not to be used during pregnancy or lactation. Not to be taken by children under 8 years. **Legal category:** GSL **Packs:** Stressless (PL 17418/0002) – 75 Tablets, RSP £5.95 (£5.06 excluding VAT)

A DIOMED PRODUCT

WHOLESALERS

More wholesalers question the future of additional services

More wholesalers have addressed the potential need for them to charge pharmacists for the additional services they provide in the face of decreasing margins.

Endorsing the remarks made by Jeff Harris, executive chairman of Alliance UniChem (*C&D June 22, p10*), Steve Dunn, managing director of AAH Pharmaceuticals, said it was time for the issue to be debated openly and frankly.

"Wholesalers are being asked to deliver more than ever before in helping community pharmacy evolve into its new role in the front line of healthcare provision," argued Mr Dunn, who is also the chairman of the British Association of Pharmaceutical Wholesalers.

He added that wholesalers were investing heavily in the research and development of initiatives such as electronic transfer of prescriptions and medicines management, with little or no help from the public purse.

"Pressure on wholesalers is increasing on all sides and put simply, something has got to give. In my opinion, where wholesalers tangibly add to a pharmacists' bottom line – and there can be no doubt that they do – there should be no problem with an extra charge for this service.

"I believe that it is time for wholesalers to be brave and take this logical step forward," Mr Dunn urged.

He also stressed that educating their customer base on the need for this change was a key challenge for wholesalers in this process.

Charges may be the only way for wholesalers to stop the decrease in margins caused by demands for additional services

David Cole, Phoenix Medical Supplies' new chief executive, agreed that charges may be the only way for wholesalers to stop the decrease in margins. A major factor in Mr Cole's view was the decrease in the percentage of a pharmacy's business placed with full line distributors, due to a shift towards shortliners.

"Traditionally, a full-liner could expect to get 75 per cent of a pharmacy's business – now it can be as low as 50 per cent. You've got to do something about that if you want to maintain margins," Mr Cole said.

He suggested that wholesalers could introduce charges for the second daily delivery or on low margin, slow moving items.

"The fundamental question is not what we do about charges, but what we can do to make the retailers go back to ordering from full-liners."

Mr Cole added, however, that unless something came out of the remuneration review and discussions about the new contract, wholesalers' hands were tied.

Meanwhile, Mawdsleys' managing director, Ian Brownlee, believes that such charges would not only provide wholesalers with additional revenue but they could also ensure that better use was made of their resources. By levying charges and establishing which services pharmacists consider worth paying a fee for, wholesalers could focus their efforts on customer needs.

"People tend to make better use of things they pay for. Maybe the real debate is what services wholesalers can and should provide and what services are valued by pharmacists," Mr Brownlee concluded.

But UniChem's managing director, Chris Etherington insisted that UniChem's belief in offering added value services to its customers has proved a very successful strategy.

Mr Etherington made clear that charging for services was not on UniChem's agenda at this time. However, he would not rule out a review of that position in the future.

"The market is in a continuous state of flux and we must always be ready to react accordingly to industry changes.

"An industry change to wholesaler charges is perhaps a possibility for the future but the timing and the extent of any change is impossible to predict."

RETAILING

Numark thriving after 'challenging' year

Numark's year-end turnover, boosted by its joint venture with Phoenix Medical Supplies, leapt 70 per cent to £28.3 million.

The joint venture – Numark Trading Ltd – supplies OTC medicines on a once weekly basis to independent pharmacies. It reported a turnover of £31.5m for the 10 months to January 31, 2002.

Numark's operating profits grew 2.1 per cent to £6.7m.

During the year it paid £6.4m in rebates to its members – an average of £7,429 per member.

By the end of last year, its membership had risen by 6.7 per cent to 1,487.

David Wood, Numark's managing director, said the year had been challenging, with concerns that independents would sell their businesses to multiples. "However, our results show that we have emerged from 2001 significantly stronger than we entered it – testimony to the fact that independent pharmacy is not only alive and well, but thriving."

SURVEY

Drug firms need to manage prices better

Pharmaceutical companies need better pricing and reimbursement strategies because they cannot earn enough from product launches, according to a pharmaceutical consultancy.

Cambridge Pharma Consultancy (CPC) has published a report – *European Pricing & Reimbursement Review 2001* – which notes that the top 16 drug firms in Europe launched only 10 products in 2001. That was the second consecutive year the launches had fallen.

Few companies, it adds, managed to get new drug prices that were higher than competing products. Firms, meanwhile, are under pressure from European governments to cut costs.

CPC's report advises the firms to concentrate on "managing" their prices. "With fewer new products reaching the market, and more restrictive regulations facing those that do, the days of focusing solely on target launch price are over. Sustaining post-launch prices is now a key," it says.

BLOATING AND TRAPPED WIND

Bloating and trapped wind can make people feel miserable. No wonder. Fullness, heaviness, stomach discomfort and sharp upper abdominal pains can all make life very difficult.

But however trapped wind behaves, the name you can trust to recommend is Setlers Wind-Eze. Because Setlers Wind-Eze has more simeticone than other single ingredient brands, and is the only leading brand designed specifically to disperse trapped wind, quickly and discreetly.

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Product Information. Presentations: ***Setlers Wind-eze*** – Simeticone Ph. Eur. 125mg in a white tablet and ***Setlers Wind-eze Soft Gel Capsules*** – Simeticone Ph. Eur. 125mg in a white soft gel capsules. **Dosage & Administration** 1 tablet ***Setlers Wind-eze*** to be chewed before swallowing, or 1 ***Setlers Wind-eze Soft Gel Capsule,*** to be taken 3 or 4 times daily or as required after meals. Not recommended for children under 12 years. **Uses:** Antiflatulent defoaming agent for the symptomatic relief of flatulence, wind pains, bloating, abdominal distension and other symptoms associated with gastrointestinal gas. **Precautions:** Should not be used by patients with known hypersensitivity to any of the ingredients. Do not use for longer than 14 days. Seek medical advice if symptoms persist or worsen. May be used safely during pregnancy and whilst breast feeding. **Legal Category:** GSL. **Cost (inclusive of VAT):** ***Setlers Wind-eze*** – £1.95 (10's), £3.45 (30's). ***Setlers Wind-eze Soft Gel Capsules*** – £3.49 (20's). ***Product Licence Numbers: Setlers Wind-eze*** – PL0036/0084, ***Setlers Wind-eze Soft Gel Capsules*** – PL0036/0073. Further information available on request from Medical & Consumer Affairs, GlaxoSmithKline Consumer Healthcare, 980 Great West Road, Brentford, TW8 9GS. **Date of revision:** Sept 2001. Setlers and Wind-eze are registered trademarks of the GlaxoSmithKline Group of Companies.

gsk GlaxoSmithKline

Phoenix depot goes twice daily

Phoenix Medical Supplies' Cardiff depot has introduced twice daily deliveries to its 200 customers. This is the wholesaler's second Welsh depot to increase delivery rates – the Plympton depot recently began offering this service. The Cardiff warehouse has also raised the number of ethical lines stocked to 6,000, invested in a new semi-automatic conveyor and taken on six extra staff.

First Numark EGM

Numark will be holding the first of two conversion extraordinary general meetings for shareholders on Friday July 5 at 11am. The venue is the Metropole Hotel at the Birmingham NEC. The meeting is to approve the following resolutions: convert into a public company; implement the Offer for Subscription; adopt a memorandum of Association; adopt articles of Association.

Avicenna launches ACE Club

Avicenna is launching the ACE club, which offers subscribers additional benefits on ethical and OTC business in return for guaranteed support for marketing initiatives. The free membership also entitles participating pharmacists to a 50 per cent reduction in the fee for CPI+ membership, UniChem's marketing and category management scheme.

RETAILING

No industry support for pharmacists who buy PIs

Pharmacists may get little support from pharmaceutical manufacturers in establishing medicines management services if they continue to use parallel imports as a source of income, an industry figure has suggested.

Sir Tom McKillop, the chief executive of AstraZeneca, condemned the practice at an informal press reception.

"As long as pharmacists insist on using PIs they can't expect any support from us," said Sir Tom.

Meanwhile, GlaxoSmithKline's fixed quota system for European wholesalers – designed to prevent PIs – could be thrown out by the European Parliament this autumn.

The Industry and External Trade committee of the European Parliament accepted an amendment filed by MEP and pharmacist Bashir Khanbhai, which aims to scrap the quotas.

The amendment states that "the marketing authorisation holder of a medicinal product shall provide uninterrupted supply of that medicinal product, marketed in the concerned member state, to wholesaler distributors registered in these member states, so that the provision of the medicinal product to patients through pharmacies and hospitals is ensured."

Mr Khanbhai believes that by introducing supply restrictions to European wholesalers, manufacturers are causing unacceptable disruptions to the supply of essential medicines to patients. They are also contravening the principle of a single free internal market.

A spokesman for GSK said it was not aware of any disruption of supply, adding that, if it discovered a problem, every effort would be made to address it.

Wholesalers are adamant that manufacturers will not be able to cut them out of the supply chain and deliver to pharmacies directly.

The European Wholesaler Association GIRP's president, Seppo Morri, said: "The concept of 3,000 manufacturers working individually with 130,000 retailers, selling 50,000 medicine products is not realistic."

Mr Morri added that full line wholesalers were the vital link, ensuring the safety and continuous supply of medicines between manufacturers and dispensing pharmacies and therefore to patients and consumers.

RETAILING

Wholesalers support Nucare scheme

Two national wholesalers, AAH Pharmaceuticals and UniChem, and two generic manufacturers, Alpharma and APS Berk, are taking part in Nucare's recently launched share incentive scheme.

Points will be awarded to Nucare pharmacists who obtain supplies from either AAH or UniChem on Nucare terms.

Moreover, purchases of APS and Alpharma generics via AAH or UniChem will attract a point for every pound spent.

The share incentive scheme is designed to allow members to earn points which will give them the opportunity to subscribe for Nucare Shares at a 50 per cent discount in any future public offering of shares by Nucare.

MULTIPLES

No merger for Boots and Sainsbury's

Boots chairman John McGrath has tried to put an end to the recurring rumours of a merger between the healthcare group and supermarket giant Sainsbury's. He said the rumoured merger "was not on the agenda".

"I just don't see the logic of it. We've got 1,450 stores and most, except 100, are in town centres. Lots are medium-sized stores in market towns. Frankly, I don't see that fits with a very focused supermarket group, which is substantially edge of town," explained Mr McGrath, who was talking to the *Sunday Telegraph*.

Rumours of a merger between the two groups have been circulating for nearly two years, and it has lately been fuelled by the two companies' close co-operation over an in-store pilot at several Sainsbury's branches.

2,500 patients are said to have signed up to the Peterborough-based electronic transfer of prescription pilot run by Flexiscript, the consortium which includes Boots The Chemists, National Co-operative Chemists and UniChem. The pilot went live at the beginning of June and is eventually expected to involve 22 surgeries and 30 pharmacies. The pilot's first pharmacy site was the Thomas Walker pharmacy. Pictured at the pharmacy are pharmacist Shabbir Damani and Norman Peacock, a patient and member of the User Assurance Group for Flexiscript

Back on TV

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This will be music to the ears of 4 million sufferers*, so make sure Pepcidtwo is the ONE you stock & get ready to cash-in on those extra sales.

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Goes to work within 2 minutes

Balances acid for 12 hours

PEPCIDTWO ESSENTIAL INFORMATION Product name: PEPCIDTWO, chewable tablet. **Presentation**: Rose coloured, round, flat chewable tablet containing famotidine 10mg, magnesium hydroxide 165mg and calcium carbonate 800mg. **Uses**: Short-term symptomatic relief of heartburn, acid indigestion or excess acid symptoms. Dosage and **Administration**: adults and adolescents over 16 years old: chew one tablet thoroughly when symptoms occur. No more than 2 tablets to be taken in 24 hours. The maximum continuous treatment period is 6 days. Patients should not purchase a second pack without the advice of a pharmacist or doctor. **Contraindications:** Hypersensitivity to the active substances or any of the excipients. Medical advice should be sought in case of moderate or severe renal failure, severe hepatic impairment, patients with any other illness or taking other medications, middle aged or older patients with digestive troubles occurring for the first time or if these symptoms have recently changed, patients with unintended weight loss associated with dyspeptic symptoms. **Precautions:** Patients should seek medical advice in case of: difficulty swallowing or persistent abdominal discomfort or taking non-steroidal anti-inflammatory drugs, especially the elderly. As Pepcidtwo contains sucrose and lactose, patients with fructose intolerance, glucose-galactose malabsorption syndrome, sucrase-isomaltase deficiency, lactase insufficiency or galactosaemia should not take this medicine. **Side Effects**: headache, nausea, diarrhoea, dizziness, nervousness, flatulence, eructation, dry mouth, thirst, paraethesia, abdominal distension, abdominal pain and taste perversion. **Legal category:** GSL, **PL number** PL13249/0029. **PL Holder**: Johnson & Johnson MSD Consumer Pharmaceuticals, High Wycombe, HP10 9UF. Packaging quantities, Price: 6 Tablets, £2.25, 12 tablets, £3.85. Date of preparation: May 2001. *Ipsos RSL Consumer Omnibus Surrey amongst 1,930 adults April 2001.

Johnson & Johnson • MSD
CONSUMER PHARMACEUTICALS

Controlling the market

The National Pharmaceutical Association has submitted its case to the OFT for retaining the status quo with the current control of entry regulations...

More outlets in the marketplace would not address the current problem of a lack of pharmacists to run them

Should the control of entry regulations be removed, the focus of pharmacy services will shift from patient care to that of "outmanoeuvring" competing pharmacies.

At least that is what the NPA's submission to the Office of Fair Trading's (OFT) inquiry into pharmacy services says. But an earlier draft had considered using the term "killing off"– a more succinct but less politically correct way of saying what could happen.

The submission has finally been put into the public domain, some weeks after the Association first met with the OFT to discuss the implications of the main thrust of the OFT inquiry – whether the control of entry regulations should be relaxed.

The NPA argues that the current system actually works for the benefit of patients, helps support the Government's plans for the provision of healthcare and also provides a positive input into the social fabric of communities across England.

But the submission warns that, should pharmacies be allowed to proliferate with no controls, pharmaceutical care would suffer. While there would be an increase in pharmacy openings, "there are insufficient pharmacists available to meet current demand, let alone any increase".

Another potential adverse effect would be that it would "leave dispensing doctors in an uncontrolled environment in which they could immediately expand dispensing to all patients on their lists.

"This would hand them a monopoly on supply of medicines and reduce patient choice, to say nothing of denying people access to proper pharmaceutical services under the supervision of a pharmacist."

Don't forget, too, that bodies corporate owned by doctors already exist. "Removal of the regulations will lead to a proliferation of such companies ... such an arrangement, where there is no separation between the prescriber and provider of medicines, is hardly in the best interests of probity," says the NPA.

Much of the NPA's case for the status quo is based on the premise that there is a finite need for pharmaceutical services. Increasing the number of pharmacies would dilute the level of service provision per outlet and would result in smaller pharmacies being forced to close. At the same time there would be clustering of pharmacies around GP surgeries while more distant outlets, particularly in socially deprived areas, would fail to thrive and could close.

The NPA has challenged the OFT's assumptions about pharmacy. From the outset, it has believed that the OFT's figures were wrong. When the inquiry was announced, the OFT stated that the overall retail pharmacy market was about £18.7 billion for 2001. "We do not know how the OFT has arrived at this figure but would query its accuracy," says the NPA.

"We estimate the average pharmacy turnover to be around £700,000. With around 12,700 pharmacies in the UK, the total turnover for the pharmacy sector is around £8.89bn – well short of the figure quoted by the OFT.

"Of this, we believe the turnover for retail activity, as opposed to the provision of NHS pharmaceutical services, to be of the order of £1.78bn."

"It is not clear why the OFT has reason to believe that consumers receive anything less than a square deal from pharmacies," says the NPA. "We submit that the Regulations have neither reduced supply nor increased prices. Rather, they have provided benefits to consumers through encouraging a more rational distribution of pharmacies and by improving the range of products and breadth of services available from pharmacies."

One explanation for this is the "relative stability afforded by the Regulations" which "has given pharmacists the confidence to develop services".

NPA chief executive John D'Arcy sees the current set up as an effective way for the Government to discharge its duty of ensuring patients have widespread access to NHS pharmaceutical services.

"As part of its stated objective to deliver the targets of the NHS Plan, the Government is seeking to make greater use of the skills and expertise of community pharmacists," he says. "A core component of this is the community pharmacy network, which not only delivers ready access, but also a platform from which to launch a range of 'added value' services.

"Its importance in enhancing pharmacy's contribution to primary and secondary care, and its potential in assisting the Government's delivery of healthcare policies and targets is indisputable."

But he warns: "The free market cannot be relied upon to do this." After all, NHS pharmaceutical services have to be managed.

When the nine-month review was announced last year, the OFT said that "restrictions on where pharmacies can open may have an effect on retail competition and not just in dispensing prescriptions. The OFT will examine the system to see how the present restrictions affect competition and consumers as well as investigating whether there are alternative ways of achieving the public interest objectives behind the present arrangements."

Thankfully, from the outset, the OFT has indicated it has no hidden agenda in reviewing the present system. "We have an open mind," it said. So far, it appears to have been true to its word.

SURVEY

Ombudsman: one pharmacist case

The Health Service Ombudsman's annual report for England for 2001-02 includes just one case involving a pharmacist.

The complaint against H I Weldrick Ltd involved a customer who discovered that the tablets dispensed and labelled as aspirin contained penicillin tablets to which the customer was allergic.

At the time of dispensing, the pharmacy pre-packed a number of drugs, including aspirin and penicillin.

The customer expressed concerns about distractions to staff in the busy dispensary and about the checking procedures.

On investigation the Ombudsman found the pharmacist professionally competent and the pharmacy well equipped and organised. But the company's dispensing procedure was found to be an overview rather than a model, and the complaint was upheld.

On the Ombudsman's recommendations, Weldrick's issued a dispensing and checking procedure in line with the Royal Pharmaceutical Society's standard operating procedures, and agreed to study the level of noise and distraction within its premises and its effect on the dispensing process.

The agency completed 225 investigations, including 48 involving GPs, seven involving dental practitioners, 166 about hospital or community trusts, and three about ambulance trusts.

For more information:
www.ombudsman.org.uk

INDUSTRY

PAGB code breach results in reprimand for GSK

The OTC industry's trade association has reprimanded GlaxoSmithKline Consumer Healthcare for breaching its advertising code of practice for professionals.

An appeal committee of the Proprietary Association of Great Britain upheld three out of four complaints made by Pharmacia against GSK's adverts for NiQuitin CQ, which appeared in *C&D* during 2001.

Despite the advertisement being described by the PAGB as "technically correct" and that it "reflects standard reporting of smoking cessation studies", the appeal committee believed it to be "open to misinterpretation by pharmacists and pharmacy assistants". GSK has expressed disappointment at the ruling but says it will respect the decision and fully abide by it. "The ruling hinged on whether communications of an odds ratio could potentially be misinterpreted by pharmacists and pharmacy assistants," said GSK. The data supporting the NiQuitin Lozenge had not been challenged, and the validity of odds ratios as a measure of effectiveness is not in doubt, said GSK.

For more information:
www.pagb.org.uk

CLO recalled after possible cancer link

High levels of chemicals linked to cancer have been found in cod liver oil sold by two high street retailers.

The Food Standards Agency has asked Superdrug and Holland & Barrett to withdraw two batches of cod liver oil. The products were found to contain more than twice the daily tolerable level of dioxin and dioxin-like PCBs, if the products were taken at the recommended dosage.

For more information:
www.foodstandards.gov.uk

Comment from the Editor

Repeat dispensing suddenly seems a lot closer with the news that 30 pilot schemes could be up and running in England in the autumn. That is if information technology is willing. Unfortunately, the short time frame in which primary care trusts have to put forward their plans to the Department of Health could mean there are more teething problems than necessary. The good news is, though, that if this autumn's deadline is met, it will put repeat dispensing on track for a country-wide roll out by 2004.

In theory, this should go some way to freeing up GPs' time, and making it easier for patients to obtain their medicines. But in practice, there may be many hiccups to be overcome, and there is even the question of whether it will actually save money in the long run or just increase medicines hoarding.

Sounding as though we are a Cassandra (although not wanting to be) we can see some difficulties. Will the software for GPs be ready in time to generate a certain number of repeat slips along with the original prescription? What sort of filing system will pharmacies need to introduce to keep myriad pieces of paper and make sure they are current? What is to stop a patient having several prescriptions around the town all running concurrently – the busy young asthma sufferer springs to mind? And what about the simple problem of the GP's printer being out of kilter with the prescription form?

The DoH needs to guard against the negative aspects causing an adverse impression of what should, on the whole, be a major improvement in helping health professionals plan their time. To its credit, the DoH recognises the need to recompense contractors for the upheaval the new system will involve. But once the system is extended to all, prescribers will include nurses, increasing the amount of paper records held in dispensaries. Roll on the roll out of electronic prescribing.

And what about the simple problem of the GP's printer being out of kilter with the prescription form?

Yourviews

The debate over the use of sunscreens on children is raging in this column. Young skin must have high SPF protection, says Dr Jane Oppenheim

Let parents be the deciding factor

I'd like to respond to the remarks Graham Hill, managing director of Delph sun cream, recently made about sun creams that exceed SPF 30 *(C&D, June 15, p12)*.

He is incorrect in many respects. He starts by asserting that "an SPF 30 cuts out 96.7 per cent of erythemal solar radiation..." If he had read the Australian/New Zealand Standard AS/NZS 2604:1998 he would have seen that this old notion is misleading. The percentage of an erythemal dose received depends on how long you spend in the sun.

However, for any time spent in the sun an SPF 60 is twice as effective as an SPF 30 (for instance) in filtering out sun burning radiation.

The Australian Government has only set a limit of 30 for the SPF in respect of sunscreen labels. There is no limit to the SPF that publications for health professionals, such as pharmacists and medical practitioners, can advise their readers. And these health professionals are free to advise the general public of the measured SPF.

A limit of 30 was set by Standards Australia for labels, but this was not because it was considered that there was no value in using higher SPFs; indeed many dermatologists recommend sunscreens with SPFs considerably higher than the limit. The main reason that an upper limit was set was the difficulty in measuring SPFs higher than 30.

Recent advances in our understanding of these problems has meant that it can now be

Dr Jane Oppenheim: "An SPF 60 is twice as effective as an SPF 30"

realistic to claim higher SPFs.

The reason for advocating the use of very high SPFs is that a small fraction of the amount of UV necessary to produce a sunburn may damage your DNA – and this can lead to skin cancer, melanoma, and premature ageing of the skin in later years. You do not need to get sunburn to damage your skin.

It is particularly necessary to protect children because epidemiological studies show that the risk of such chronic effects are greatly increased by excessive childhood exposure. This relates to everyone with a child, not to "a tiny minority".

Ego Pharmaceuticals *(Dr Oppenheim is scientific director of the company)* believes that parents have the right to choose the most protective sunscreens to protect their children. On my children I want the best protection.

BlackBAG

Counterfeit goods

Local medical committee representatives from all over the UK recently held a special conference to debate the proposed *New Contract* for GPs. The backdrop for this meeting is a turmoil of discontent.

Government delegated the task of producing the contract to the NHS Confederation. Months of negotiation produced a document called *Your Contract, Your Future* on which the whole profession could vote yes or no to proceeding with pricing the recommendations as a total package.

There was heated debate at the conference, with not a little acrimony. One speaker offered the conference representatives watches, handbags and sunglasses which were patently counterfeit. Lifting the *New Contract* document above his head he showed another "counterfeit" to a standing ovation.

There is a great deal at stake, not just the credibility of the BMA negotiating team but also the future of the NHS itself. Failure to reach agreement may provoke a mass resignation among

Built into the deal is the abolition of out of hours as a commitment

NHS general practitioners. Built into the deal is the abolition of out of hours as a commitment. Even suggesting such a thing 10 years ago would have produced raucous laughter, now it is a very real possibility. It is difficult to overestimate the impact this would have on many a GP's life. A whole generation of family doctors now see out of hours work as anathema. Unfortunately there is also a dire lack of doctors – we have the least per head of population in Europe – but for most GPs they are simply glad that it's no longer their problem.

Hidden agendas abounded, with accusations of "NHS wrecking" flying across the conference room. Emotional stuff. This may be a counterfeit document, but like a Rolex, if no-one can tell the difference, does it really matter?

Dr Ian Banks is a GP practising in Northern Ireland

TOPICAL REFLECTIONS

Herbal medicines – marketing replacing efficacy?

Eventually the European Union will agree on a common approach to the control of herbal medicines but meanwhile, as Beverley Parkin, director of public affairs at the Royal Pharmaceutical Society, says: "Controls over the sales of herbal products used medicinally are weak" *(C&D Lambeth Outlook, June 22, p8)*.

Beverley outlines the current plans of the European Commission, which wants controls of the sale of herbal products to be in place in all member states by the end of December 2004. But it is not clear to me whether these controls will only apply to licensed products, or to the whole range of products presently marketed under food regulations.

The alternative medicines and supplements industry – with a few notable exceptions – does not want its products to be controlled by any licensing procedure that requires medicinal claims, whether positive or implied, to be verifiable by evidence of efficacy. They have therefore concentrated on diverting the EU's attention away from claims of health benefit towards concerns about safety. And they seem to be succeeding.

All this manoeuvring in the corridors of power has, however, overlooked the requirements of the consumer. Yes, the consumer requires the reassurance that products they are taking are safe, but more importantly they want reassurance that the health benefit they expect will be delivered. The fact that many "miracles" are sold by media publicity and on the back of vague packaging that says nothing while implying everything, merely exposes the inadequacies of the present system.

The general public are very gullible. Those suffering from the more disabling degenerative diseases of modern society are highly vulnerable to accepting claims that will provide the hope and cure that conventional medicine seems unable to deliver.

Meanwhile, as a pharmacist, I am expected to provide evidence-based advice not just about the products that I sell, but also for those purchased from other outlets. An almost impossible task that should be made easier by a tightly-drawn EU directive enshrined in UK law. But I fear my task will be frustrated by an industry more concerned with profits than with probity in its marketing.

Confusion over cod liver capsules

Seven Seas' Neutrataste taste-free cod liver oil capsules sell well because consumers like the idea of taking cod liver oil but not being reminded that they have taken it! Available in 1,000mg and 500mg capsules, I should have no complaint against cod liver oil except for my long standing campaign against "one-a-day" marketing.

Both sizes of capsule are marketed as "one-a-day", yet in contents are pro-rata to one another. This contradiction however, is insignificant when compared with the warning on both packs which says: "Exceeding the suggested intake is not recommended." Logically, the 1,000mg capsule daily is an overdose if the advice on the 500mg pack is adhered to. Recently a lady asked me to explain this contradiction and I ended up as confused as she. Perhaps Seven Seas has a rational explanation?

A test of customer honesty

George Orwell famously wrote that "all men are equal but some are more equal than others". Now SSL International has taken that maxim on board by announcing a new range of Durex condoms – to be launched by the end of the year – that recognises the different sizes of man.

In future I will have to be very careful when training my young lady counter assistants. No longer will the request for Durex, met by "which size please?", be a joke but a serious question that will have to be dealt with very, very carefully!

If something goes wrong, take time to find out why and learn from your mistakes, says *Steve Eastham*, Boots' head of clinical governance

Eliminating errors

Incidents and near misses are occasions where the defences built into our dispensing processes are shown to be inadequate. Clearly in the case of a near miss, the error was caught before a patient suffered any harm. But the experience can still show us where our precautions against mistakes have a weak spot. To improve patient safety we must take each incident or near miss seriously and understand which parts of our process went wrong. Then we can consider what additional defences are needed to prevent it happening again.

There are particular benefits when the pharmacist systematically records near misses and incidents and the action taken to prevent them. These include:

- recurrent problems may be spotted more quickly
- trends in frequency of near misses and incidents can be noted
- the information is a useful training aid
- recording what is going wrong and what has been done to prevent a recurrence demonstrates a responsible and professional approach.

Types of error

As healthcare professionals, all our actions are taken with the care of our patients in mind. Similarly, the people we employ in our pharmacies act with the patient's welfare uppermost in their mind. It is natural for us to assume that every decision and action is going to cause no harm to patients. This may be an unreasonable assumption because, no matter how good our systems and our people are, there is always a risk that something will go wrong.

James Reason's *organisational causes of accidents* model shows there are always factors at work that can lead to patient harm.

The incident or accident itself arises from an active failure, either an error or a violation, which gets past the defences built into the dispensing process.

An error is the failure of a planned sequence of events to achieve the desired goal. There are three types of error. Firstly, there are slips in which the plan may be adequate but it is not carried out as intended, for example, putting the iron away in the fridge.

Secondly, there are errors known as lapses, which are failures of memory or attention. For example, you intended to stick a label on a bottle but the phone rang and you put the unlabelled bottle in the bag. Slips and lapses are known as "skill-based" errors because they occur during the automatic performance of a routine task in a familiar environment.

The third type of error is a "rule-based" mistake and is the result of applying knowledge incorrectly or incompletely. For example, when encountering a prescription for a new formulation of a familiar product, one may have no knowledge of the new formulation and dispense the original product.

A violation, on the other hand, is an action that one knows to be unwise or against existing rules and protocols, but which seems sensible at the time. For example, you know someone else should double check your dispensed prescription but it's a busy morning so you decide to do it yourself.

Causes of error

Errors and violations have triggering factors – conditions that increase the probability an individual will make an error or take an unwise action. Triggering factors can be made more likely by latent factors in the system.

Latent factors tend to be general and concerned with how

Continued on page 18

Are you sure that's the right dose, the right drug for the right person? Mistakes can happen but there are safeguards to avoid errors

Continued from page 18

the practice is managed. They are present all the time. They can include, among other things, the attitude to patient safety, the degree of organisation, the attitude to training, and staff motivation.

Triggering factors tend to be more immediate and may occur only for a short time. There are four key areas that give rise to triggering factors in dispensing:

1. They may arise within the existing processes if steps are completed incorrectly or in the wrong order. There are many examples, including selecting stock by reading from the label instead of the prescription, self checking, storing medicines incorrectly or haphazardly, storing completed scripts untidily and not following date checking routines.

2. The nature of the practice environment may give rise to errors and violations, for example, the presence of noise and distraction, poorly laid out working areas, inadequate space or allowing non-dispensing tasks to be completed in the dispensary.

3. Triggering factors may arise from the way individuals work as a team, for example inadequate training, trained staff who are not competent, lack of understanding of their responsibilities, and poor communications between team members.

4. Individuals may give rise to triggering factors. They may have personal problems on their mind; they may be tired or not feeling well. They could tend to be distracted easily, or exhibit distracting behaviour for others in the team. They may not communicate very well.

In pharmacies there are many precautions built into the dispensing process to catch errors and violations before they do any harm. The defences we put in place must be able to withstand the pressures associated with the pharmacy environment, so must be robust. Examples are:

- our personal accuracy check
- patient counselling
- staff training
- staff competence assessments
- dispensing protocols
- high awareness of risks and how to manage them
- systematic recording of incidents and near misses
- dispensary design
- pharmacy environment (light, heat, noise, distraction)
- dispensary computer system (PMR, interaction and contra-indication alerts).

Research in the USA has shown there are some surprising danger times for pharmacists and staff involved in the dispensing process. Considering these is important to encourage us to challenge our assumptions about the safe operation of dispensaries.

A quiet dispensary may be more risky than a busy one. Staff may be over confident and there may be insufficient tasks in the dispensary to keep the mind focused. There may be little variation in exposure to prescriptions and so, while staff may have worked there for a long time, they may not have had many different experiences. Because they do not need all their mental capacity to deal with the professional tasks, they may be distracted more easily. These characteristics may not be present in a busy dispensary where the professional work keeps people fully occupied.

Sara B'Kranz

"We expect our minds to change immediately from being on break mode to operating at full speed"

We all recognise the importance of taking a break; however, it can also introduce unexpected risks. We expect our minds to change immediately from being on break mode to operating at full speed, especially where patients are waiting impatiently for our return.

At the gym, a warm-up period to prevent damage to muscles is important, and we need to give our minds the same treatment after a break. Prudent pharmacists may therefore take steps to warm up their minds again before they hand over a dispensed medicine to a patient.

Personal problems affect us all at some time and as professionals we try to keep them out of our working life. However, we are only human and, no matter how hard you try, unwelcome thoughts may still surface while you are dispensing.

Where there is an increased potential for distraction the professional response is to make sure that additional care is taken to avoid errors getting through your defences. Letting colleagues know that you are a "bit under the weather" will encourage them to take more care before presenting a prescription to you for checking. You may adopt a double check approach yourself where you consciously check everything you do again.

"Unwelcome thoughts may still surface while you are dispensing"

Research has also shown that undiagnosed deficiencies of eyesight or hearing can contribute to incidents. Much of a pharmacist's activity is reading, so any impairment of sight can be crucial to correct interpretation.

Much communication is also by telephone where only the spoken word is available to get a message across. The consequences of not hearing a dose instruction clearly can be catastrophic.

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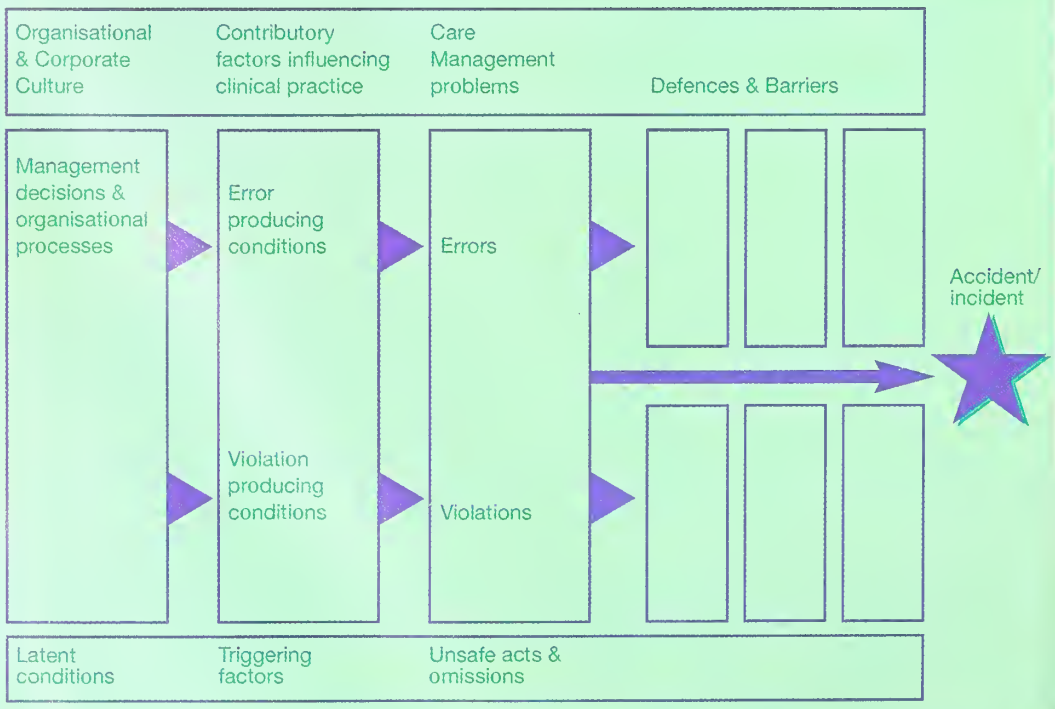
Model of organisational causes of accidents



from Reason[1] and Vincent et al[2]

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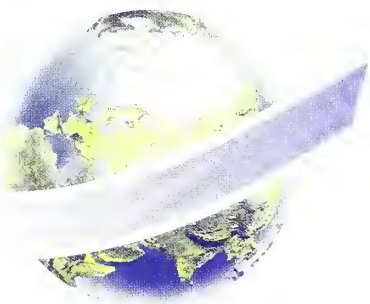

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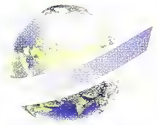
2

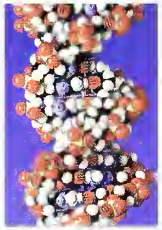
FORMULARY FACTS

Isosorbide Mononitrate



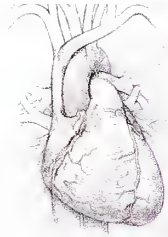
neolab

Nitrates have been used for over 100 years in the management of angina. Isosorbide mononitrate, the active metabolite of isosorbide dinitrate, is used in the treatment and prophylaxis of angina pectoris. It is a safe, well-tolerated molecule with few direct drug interactions.



A number of once-daily preparations are available but most brands are not bioequivalent. Care should therefore be taken when changing brands.

ISMO effects



Primary mode of action is venodilation. This reduces preload, which lowers myocardial oxygen demand.

Dilation of coronary arteries in the subendocardium improves oxygen delivery.

Dilation of peripheral arterioles reduces systemic vascular resistance and hence reduces afterload.

Dilation of cerebral arterioles causes headache, which is a class effect. Facial flushing occurs through a similar mechanism.

All nitrates can cause sudden hypotension. Dizziness, flushing and weakness result, particularly on standing or with sudden changes in posture. These effects are more common in the elderly and those taking antihypertensive medication. Nitrates should never be used to treat hypertension, although they may be used alongside other antihypertensives.

Counselling points

- Headache can be managed with paracetamol. Headaches, as well as flushing and dizziness will subside with time.
- Frequent dizziness, particularly if associated with falls or syncope, requires re-evaluation of therapy.
- Angina patients should always have GTN available for use on a PRN basis.
- Nitrates are available as: short and long acting tablets, sub-lingual tablets and spray, buccal tablets, ointment, transdermal patches and IV infusion.

2 FORMULARY FACTS

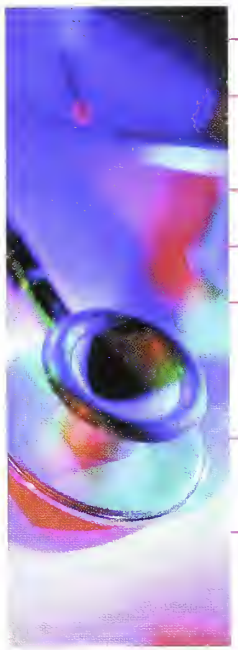
Isosorbide Mononitrate

Chemist Druggist

neolab

Identify all patients with established cardiovascular disease and offer advice and treatment to reduce risks

Angina therapy in the Coronary Heart Disease NSF (published March 2000)



GTN — GTN should be offered to all patients with angina to alleviate acute attacks.

Aspirin — All patients with angina should be taking 75-150mg aspirin daily unless contraindicated.

Beta-blocker — Considered first line therapy unless patient has left ventricular dysfunction.

Long-acting nitrate — Once daily preparations are ideal. Give at night for nocturnal angina.

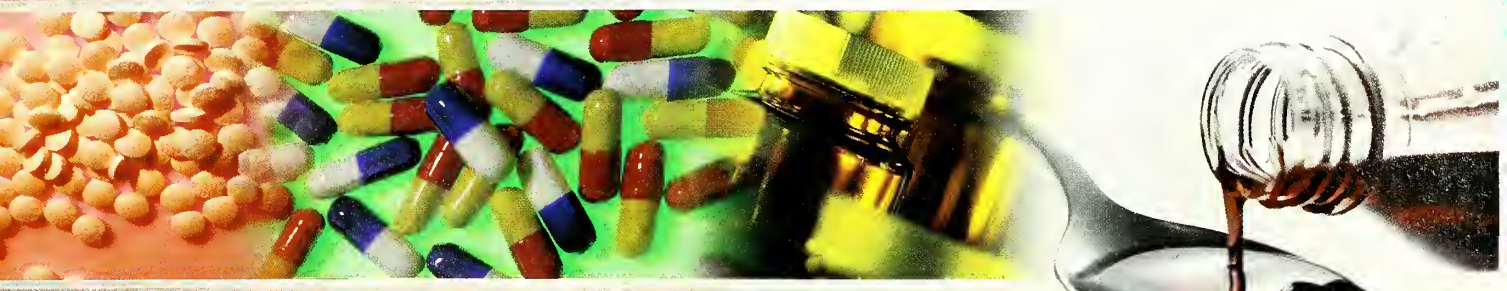
Calcium channel blocker — Dihydropyridines (amlodipine) are effective. If unable to tolerate beta-blockers, consider diltiazem or verapamil (unless patient has LV dysfunction).

Statin — All patients with angina should be considered for cholesterol reduction (30% LDL reduction).

Nicorandil — Potassium channel openers can be used safely with nitrates with no evidence of tolerance. Though often considered a fourth line anti-anginal, significant evidence supporting earlier use (for its anti-ischaemic and anti-arrhythmic properties) is changing practice.

Nitrates and tolerance

- To prevent tolerance a 12-14 hour interval between doses is recommended ie once-daily preparations are preferable.
- If nocturnal angina is a problem, create a nitrate-free period during the day.
- To reduce tolerance with twice or three times daily regimes tablets should be taken at 8am and 4pm, or 8am, 12-2pm and 4-6pm (or equivalent).
- Tolerance probably results from depletion of sulphydryl groups at the nitrate receptor site. Nitrate-free periods allow regeneration of these groups.
- If tolerance develops, doses become less effective and may give the impression of worsening angina.



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For further details contact Mary Prebble on 01732 377269.

◀ Continued from page 18

The preventative step is simple – do not wait until you notice that there is a problem with vision or hearing, have a sight and hearing test.

Avoiding errors

By understanding how incidents may arise, the pharmacist is better equipped to prevent them happening in the first place. Each pharmacy is different, although there will be many similarities. We have seen by our consideration of triggering factors that the risks to patient safety will be vary at different times of day and different days of the week. If we actively consider what the risks are, then we will be in a much better position to avoid them.

An effective way to manage risks is to ensure that critical processes in the dispensary follow Standard Operating Procedures. These tools ensure that everyone involved in the process knows what they should do. Properly constructed, they are a useful

Sara B Kranz

"Do not wait until you have a problem with vision"

training aid and help to ensure smooth and efficient operation of the dispensary.

There are some other fundamental issues to be considered. How robust is your personal checking protocol? You rely on it to catch the errors and violations of others, how consciously have you adapted it to make it more effective? What changes do you make if you have a personal problem, an experienced member of the team is off, or you are feeling tired?

What do you do when something does go wrong, even if the error does not reach the patient? Not considering changes effectively leaves a weakness in the system for the error to happen again. Next time, your defences may not catch it before it gets to the patient and it may cause harm. How will that make you feel as a professional and as a person?

What to do if an error occurs

Errors and violations will occur and occasionally get through our defences. Everyone involved is likely to feel bad. They may feel fear or anxiety over the consequences and they will be upset that a patient has been harmed. The way that we react is important, not just for the patient but also for our own feelings.

Everyone will try to be more careful. However, if this is the full extent of the action plan then sooner or later the incident will recur. If the dispensing process is changed to reduce the chances of the same thing happening again, we will know we have made a real difference. Arguably, we will feel much better about our response and our professional pride and self confidence will be restored.

When something does go wrong, it is important that you manage the patient in a professional manner. Where you can show the patient that the issue is being taken seriously, a full examination of the circumstances has taken place and a real change has been made to the way that the pharmacy operates, then they are more likely to support you. As a result they may decide not to take the matter further.

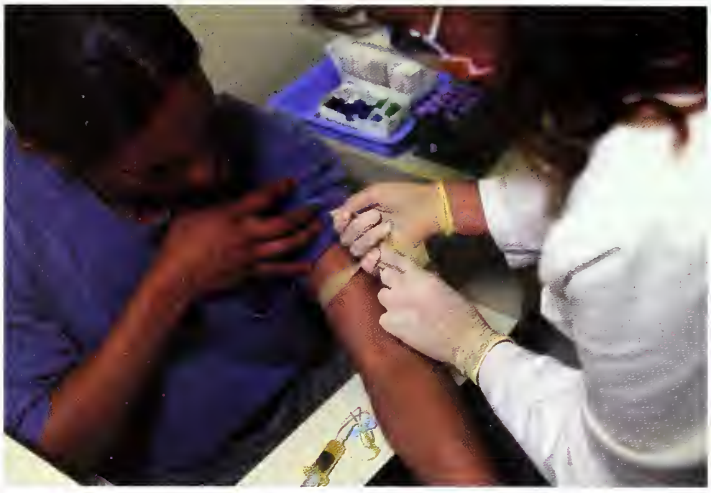
An essential part of your response is to ensure that the GP knows what has happened. It demonstrates that your foremost concern is for the patient's welfare. It also demonstrates to the patient that you are not trying to cover up what has gone wrong, and it may help you to regain the patient's trust. It will help, when you speak to the GP, if you can show that you have reviewed all the contributory factors and have taken steps to eliminate them permanently from the dispensary. If the GP is able to support you on next seeing the patient then, again, the patient may be less likely to take further steps.

In summary, when something goes wrong, take time to discover why it went wrong and take action to prevent it happening again.

NPA resource pack

The National Pharmaceutical Association will be sending members a resource pack on Standard Operating Procedures, starting in January 2003. To get advice or draft packs in advance contact Michelle Styles on 01727 832161 or *m.styles@npa.co.uk*

NICE consults on 'clotbusters'



Thrombolytic treatments need to be administered quickly

The National Institute for Clinical Excellence has issued a consultation document on the use of thrombolytic drugs in the treatment of acute myocardial infarction.

The appraisal committee's preliminary recommendations are that patients with acute MI in whom thrombolysis is indicated should receive treatment as soon as possible after the onset of symptoms.

The four drugs licensed in the UK are alteplase, reteplase, streptokinase and tenecteplase. The choice of drug in hospital should take account of:

- the likely balance of benefit and harm to the patient, eg stroke
- patients who have previously been treated with streptokinase should not receive it again
- the suitability of the drug for the hospital's organisational arrangements to reduce delays in administration.

Pre-hospital administration of thrombolytics may be necessary in some cases and the drugs administered by bolus injection (reteplase and tenecteplase) are the most suitable.

About 240,000 people in England and Wales have an acute MI each year, 50 per cent of these will die within 30 days of the event.

The closing date for comments on this consultation document is July 16.

For more information:
www.nice.org.uk

Inhaled insulin does well in trial

A small study of Type 2 diabetic patients using inhaled insulin has shown that they achieve better glucose control than those taking oral treatments.

A three-month Phase III clinical trial of 309 patients used Exubera, a dry-powder inhalation form of insulin being developed by Pfizer and Aventis Pharmaceuticals.

Patients using Exubera alone, or in combination with oral treatments, showed a decrease in HbA1c – a marker of blood glucose control – over the previous few months, compared to patients using oral treatments alone.

Exubera patients also showed significantly greater decreases in fasting plasma glucose concentrations and two-hour post-prandial glucose levels.

However, episodes of hypoglycaemia and weight gain were higher in the Exubera group.

For more information:
www.biospace.com

Probiotics may reduce weaning allergy

Supplementing the diets of weaning babies with probiotic bacteria may help to reduce the symptoms of eczema, according to a small study published in *Gut*. Twenty-one babies showing signs of atopic eczema were weaned onto hydrolysed whey formula feed. Eight babies reacted badly, and of the remaining 13, seven were fed the formulas supplemented with probiotic bacteria, *Bifidobacterium lactis*.

Stool samples revealed that those who had reacted badly to the formula had high levels of lactobacilli or enterococci. Markers of inflammation, including Immunoglobulin E, were also higher in these eight children, indicating that the presence of these "unfriendly" bacteria may be associated with atopic sensitisation.

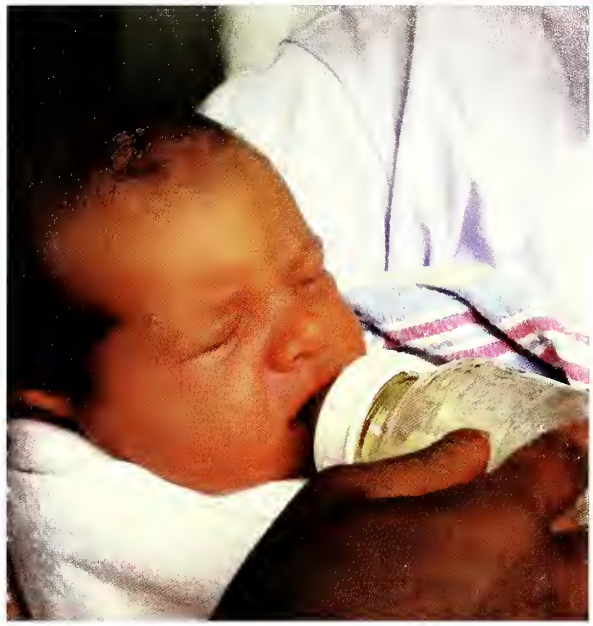
Babies who received the supplemented feed showed lower levels of gut bacteria.

The authors conclude that bifidobacterial supplementation may modify the gut microflora in a way that may alleviate allergic inflammation, but further studies are needed to confirm this.

- A study in the *Archives of Disease in Childhood* has shown that high levels of personal hygiene increase the risk of asthma and eczema in pre-school infants.

For every unit increase in a simple hygiene score the likelihood of a child wheezing increased by 4 per cent. Those children whose eczema was classified as severe (sore, weeping blisters) were associated with the highest hygiene scores.

For more information:
Gut, 2002, 51: 51-55
Archives of diseases of Childhood, 2002, 87: 26-29



High levels of hygiene may increase the risk of eczema and asthma in pre-school children

New COX-2 shows similar efficacy to indometacin

A small, short-term study has demonstrated limited benefits of etoricoxib (Arcoxia) compared to indometacin for the treatment of acute gouty arthritis.

In a randomised, double-blind, active comparator trial of 150 patients, half received etoricoxib 120mg once daily and half indometacin 50mg three times daily, both for eight days.

Both drugs showed similar efficacy in reducing pain, inflammation and the need for analgesia.

Although drug-related adverse events were less frequent in the etoricoxib group, the overall adverse experience rates were similar for both treatment groups.

Funding for the study, published in the *BMJ*, was provided by Merck.

For more information:
www.bmj.com
BMJ 2002, 324: 1488-1492

Parkinson's drugs do induce sleepiness

Up to 30 per cent of patients taking dopamine agonists for Parkinson's disease suffer from sleep attacks, according to a review published in the *BMJ*.

The review of 20 publications between July 1999 and July 2001 found that sleep events occurred at both high and low doses of the drugs, different durations of treatment and with or without preceding signs of tiredness.

Sleep attacks are a class effect for dopamine agonists and occur in people taking many of the treatments commonly prescribed for Parkinson's disease.

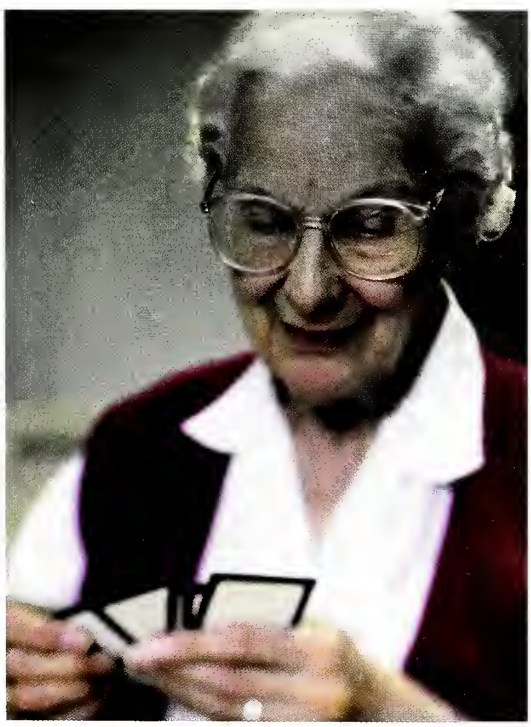
The authors of the study conclude that there is insufficient data to provide effective guidelines for the prevention and treatment of sleep events. Patients should not be advised to stop driving but should be made aware of the potential risk of sleepiness.

- Much larger trials are required to evaluate the best treatments for the disease, according to an article in the same issue of the *BMJ*.

As the population ages the incidence of Parkinson's disease will increase. Trials with long-term follow-up and end points that are relevant to patients will be required to improve treatment.

For more information:
BMJ 2002; 324:1508-1511

Elderly women's eyesight most at risk



One in 10 elderly people is visually impaired in some way, and more women than men are affected

More than half a million elderly people in the UK have poor eyesight, according to research in the *British Journal of Ophthalmology*. The level of impairment rises sharply with age and more women than men are affected.

The study of more than 14,000 people over the age of 75 revealed:

- one in 10 was visually impaired
- 2 per cent were blind, according to World Health Organisation criteria
- 20 per cent did not have eyesight good enough for driving, but in the over 90 age group this rose to almost 50 per cent.

If the study had used a US definition of "impaired eyesight" the estimated numbers would have increased by 60 per cent, according to the authors.

- Patients with glaucoma are putting their sight at risk by missing doses of eye-drops or not waiting a sufficient time between applications of different medications, according to a recent survey.

The International Glaucoma Association urged eye specialists around the world to listen to the needs of patients, most of whom would prefer to have once-daily dosing. Pharmacia has recently introduced Xalacom – a once-daily fixed combination of latanoprost (Xalatan) with timolol.

For more information:
www.xalatan.com
British Journal of Opthalmology, 2002; 86: 705-800

Scriptlines

1.5ml Penfills to go next year

Novo Nordisk has announced that 1.5ml Penfill insulin cartridges will be discontinued in December 2003.

Patients should be transferred to the 3ml cartridges. They will also need to use a new device such as the NovoPen 3, which is available on prescription.

The NovoPen 3 is operated in the same way as the NovoPen 1.5, except that the needle attaches onto the cartridge (once it has been inserted into the device), rather than onto the neck of the device.

Information for patients regarding the changes will be flagged on packs of 1.5ml cartridges from August. The company is also sending pharmacists leaflets that can be given to patients explaining the change.

For more information:
Novo Nordisk
Tel: 0845 600 5055.

Frontshop

Junior range marks start of a New Era

Seven Seas is launching a New Era children's range of homeopathic treatments.

New Era Junior is designed to provide an easy entry point into homeopathy for parents who are interested in using homeopathic preparations to treat their children's everyday ailments.

The range comprises six products – for minor skin ailments, colicky pain, hay fever and allergic rhinitis, coughs, colds and chestiness, catarrh and sinus disorders and teething pain.

The packaging features bright colours and clear labelling to make it easy for parents to choose the right remedy.

The launch will be supported by advertorial promotions in key family and parenting magazines during the summer and autumn months.

Smaller pack sizes have been introduced for eight key New Era combination remedies, which contain several different single-mineral tissue salts to treat common ailments.

The manufacturer hopes the convenient new tub sizes (180 tablets) will encourage existing New Era customers to trial different products within the range, and attract new users to homeopathy.

The original range of 18 New Era combination remedies (450 tablets) is still available.

Price: Junior (120 tablets) £2.39, Combination (180 tablets) £3.49

Seven Seas Health Care Ltd
Tel: 01482 375234.

Care offers hay fever relief

Thornton & Ross is introducing Care Cetirizine Hayfever Relief 10mg tablets as part of its strategy to build the Care range in pharmacies.

Each tablet contains 10mg of cetirizine dihydrochloride to relieve the symptoms of hay fever and other allergies.

The pharmacy-only tablets are taken once a day and are suitable for adults and children over 12.

The packs feature a Stargazer lily, a plentiful source of pollen.

The Care Hayfever Relief range is being supported by a consumer press campaign in regional newspapers and magazines. Point of sale material is also available.

Price: £3.49

Pack size: seven tablets
Pip code: 283-6757
Thornton & Ross Ltd
Tel: 01484 842217.

Holiday season sets off Pepcidtwo campaign

Pepcidtwo will be on TV throughout the peak holiday season in a heavyweight national campaign.

The new "day and night" Pepcidtwo commercial portrays someone suffering heartburn at a party. It is designed to reinforce the brand's immediate and long lasting action to tackle heartburn and indigestion symptoms throughout the day and night.

The campaign will be on air in three bursts from July 1 until the end of August.

For more information:
Johnson & Johnson.MSD
Tel: 01494 450778.

Macleans 40+ in slow motion

GlaxoSmithKline Consumer Healthcare is supporting Macleans 40+ toothpaste with a national £2.3 million TV campaign from July 1 until mid September.

The distinctive black and white commercial uses a complex split-motion production technique to "slow down time".

It shows a couple – totally engrossed in each other – dancing in slow motion, while everyone around them dances at normal speed. The product is formulated to help slow down the ageing effects on maturing teeth and gums and the commercial ends with the sign off "Macleans 40+... slow down time."

It features a new version of Roberta Flack's "The first time ever I saw your face" with voice-over by popular actress Amanda Burton.

To complement the TV advertising, a £250,000 national press campaign will appear in women's magazines throughout July and August.

For more information:

GlaxoSmithKline Consumer Healthcare
Tel: 020 8047 2700.

Lamisil^{AT} helps tackle athlete's foot

Novartis Consumer Health is introducing pharmacy point of sale material for Lamisil^{AT} primary fungicidal treatment.

The move is designed to assist pharmacies in raising awareness of athlete's foot during the summer months when the condition is more common: almost 70 per cent of cases occur in the summer season.

The point of sale material includes a counter display unit, a shield banner, showcards and giant packs.

It is available from the Novartis customer service team.

For more information:

Novartis Consumer Health
Tel: 01403 218 111.

Scriptlines

ADHD drug launch

Link Pharmaceuticals will launch a range of methylphenidate tablets on July 1.

Tranquilyn tablets, available in strengths of 5mg, 10mg and 20mg, will cost the same as Celltech's Equasym (methylphenidate) tablets.

Tranquilyn, which is indicated as part of a treatment programme for attention-deficit hyperactivity disorder, is available from all wholesalers.

Price: see this week's *Price List* supplement

Pack size: 30 tablets
Link
Tel: 01403 272451.

Aureomycin discontinued

Wyeth has discontinued Aureomycin (chlortetracycline) 3 per cent ointment with immediate effect, citing low volume of sales.

For more information:

Wyeth
Tel: 01628 604377.

Frontshop

Oxy duo help teens not to ruin their chances

Cartoon duo Angela and Chip are back on TV again in a £575,000 national TV campaign for the Oxy medicated skincare brand.

Targeting 12-16 year old girls and boys, the campaign features the strapline "Don't ruin your chances" and will be on air from July 1 until September.

The commercials focus on Oxy Daily Face Wash and Duo Pads and will be seen on national terrestrial TV and on major satellite stations including MTV, Sky, The Cartoon Network and Nickelodeon.

In addition, a £114,000 press campaign for the brand will appear in teenage titles during July and August.

For more information:

GlaxoSmithKline Consumer Healthcare
Tel: 020 8047 2700.

Inbrief

Small talk

Procter & Gamble plans to repackage Pampers nappies in smaller packs. Latest packaging technology has resulted in the company being able to put more nappies in a pack. The new packs will be available from August 2.

For more information:

Procter & Gamble UK
Tel: 0191 297 5000.

Lemsip changes

Reckitt Benckiser is discontinuing Lemsip Cold + Flu Soft Gel Capsules 8s and 16s with immediate effect. The company expects consumers to trade across the brand into Lemsip Cold + Flu Original Lemon or trade up into Lemsip Cold + Flu Max Strength Capsules.

For more information:

Reckitt Benckiser Healthcare (UK) Ltd
Tel: 01482 326151.

AAH helps pharmacies get ready for summer

AAH Pharmaceuticals is launching a "Here comes summer" marketing campaign to help Vantage members capitalise on seasonal consumer spend.

The campaign starts in the first week of July – a month earlier than in previous years – to attract consumer attention before the school term ends and the busy holiday season starts.

A promotional mailer will be sent to over 2.5 million homes local to Vantage pharmacies UK-wide.

This can be redeemed in store for a free "goodie bag", containing samples such as Pampers baby wipes, Theramed toothpaste and own-label products from Vantage.

A summer health guide is included in the bag, containing money-off coupons to family summer attractions such as LegoLand.

For more information:

AAH Pharmaceuticals Ltd
Tel: 024 7643 2000.

Femfresh cleans up on TV

Carter Products is supporting the Femfresh intimate hygiene range with a £500,000 summer TV advertising campaign.

This will be on air on Channel 4 and satellite for four weeks from July 1. The commercial has a "Fresh British summer" theme and features the strapline "Fresh, feminine, Femfresh... take the feeling with you". The brand will also be sponsoring *The real sex and the city,* a new TV documentary following the lives of 11 very different women in New York which will run on Sky One for the next eight weeks.

The sponsorship advertisements feature a woman having fun on the beach and in the countryside.

For more information:

Carter Products Ltd
Tel: 01303 858700.

Revlon turns up the heat

Revlon plans to launch a limited edition collection of fiery cosmetic colours in copper, amber and chestnut shades for autumn.

The Amber Ablaze collection will be available from August 21 until February 2003.

New for lips will be Super Lustrous Lipstick and Brush-on Shine in Amber Ablaze (copper shot with gold).

For eyes, new Eye Glossing will provide a lightweight, metallic frost finish. The product will be available in two shades – Autumn Leaf and First Frost.

Revlon will introduce three rich nail shades – Amber Ablaze, Roasted Chestnut and Glow Light.

For more information:

Revlon International Corporation
Tel: 020 7284 8700.

TV next week

Benadryl Allergy Relief: B, G, Y, A, HTV, W, M, LWT, TT
Calypso Dry Oil Spray: Sat
Daktarin Gold: C4, ITV, Sat
Durex: C4, C5, Sat
Femfresh: C4, Sat
Hedex: Sat
Lucozade Energy: All areas except U, CTV
Macleans: All areas except U, CTV
Malibu: B, G, Y, TT, GMTV, Sat
Movelat Relief: C5
Nivea Sun Children's UV Sprays: All areas
Oxy: All areas except U, CTV, GMTV
Piriton: All areas except U, CTV
Scholl Health & Beauty for Feet: All areas except U, A, HTV, CTV, W, M
Senokot: All areas

PharmaSite for next week: Dulcolax – Window, **Dulcolax** – In-store **Canesten-Hydrocortisone** – Dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, C5-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Ple@se e-mail your views to chemdrug@cmpinformation.com

Look at 'volume' data too

I would like to clarify an issue, which has once again been brought to my attention. *C&D* recently published the top 10 sun creams in terms of value, *(June 8, p28)* which bears little resemblance to the most popular sun creams sold.

Delph sun cream was the number four brand in terms of volume in 2001 and this year is projected to be even more successful.

Because it is one of the most cost-effective brands on the market we do not feature in the "value" research. Delph is fully independently tested (not on animals) and is available in SPF 2-30 as spray or cream. Not only that, but we also give away a free bottle of aftersun with every bottle of sun cream. Our prices start at £2.99.

We believe that the public should be encouraged to use the correct amount of cream per application (35ml) in order to prevent burning and therefore reduce the risk of skin cancer.

This means the average person should be using one 200ml bottle per one and a half days in the sun – adding a huge cost to their holiday if using a high priced sun cream.

With the Delph brand people can afford to apply the correct amount, which is why we are one of the most popular brands sold, but do not feature on the "value" research charts.

Graham Hill
managing director,
Fenton Pharmaceuticals

This is a fair comment but market analysts generally present brand rankings – for magazines – by value rather than volume – Editor

AAH makes the Link... at long last

We offer our congratulations to AAH who are reported in *C&D (15 June, p10)* to be introducing a LinkScan system for the remote ordering of requirements from wholesalers.

We introduced nearly precisely the same system some 10 years ago and it was received with hesitation initially because of the EAN (European Article Numbering) System, as the access code was not exactly favoured. There was and still is the PIP code, and national wholesalers were eager to have their own code system restricted to themselves to tie in customers using their own Link equipment. It was conceived and developed rather earlier.

In the meantime, our system, which was custom built for us by our software house to our specifications, itself went through successive hand-held apparatus, currently using the Hornet which is small and effective and clearly hand-held.

The writer presented the total package at a British Association of Pharmaceutical Wholesalers (BAPW) agm in Guernsey some years ago and, at every stage of its demonstration on different occasions, was hailed as somewhat revolutionary.

The complete package has many innovative elements to it, which I will not elaborate upon in this letter, but it has all been extremely successful.

Good luck AAH and pleased to have you join us so many years later!

Bernard L Dubras
chairman, Chandis Ltd

Cracking the drugs code

While the Government urges greater sharing of information between healthcare professionals, it still does not have an all-embracing code for medicines. Julie Hales reports

Even though almost all pharmacists use a computer at work, there is no standard product code that identifies all medicines and appliances across primary care, secondary care and the supply chain. A number of codes exist, such as PIP, wholesaler and EAN but none have been adopted as the universal standard.

This has always created an issue for computer suppliers when it comes to communicating with healthcare professionals or wholesalers. With the electronic transfer of prescription (ETP) pilots, in which healthcare professionals will be sending product information electronically, there is clearly an even greater need for a standard drugs code.

The NHS Information Authority consultation process indicated the growing need for a UK Clinical Product Reference Source (UKCPRS). And the Government's strategy paper, *Information for Health*,[1] published in September 1998, also noted the lack of a common code: "There is a lack of standardisation in the UK in describing medicines, appliances and medical devices; in how such descriptions are organised, and in linking knowledge required for decision support to these descriptions."

Responsibility for the integrated delivery of UKCPRS lies with the Information for Personal Health section of the NHS Information Authority (NHSIA).

The NHSIA consultation process concluded that the control of delivery of any standard drugs code should remain with the NHS and recognised that no single solution provider was likely to produce a viable solution.

The commercial sector however remains sceptical about the NHS' ability to deliver this project.

It was decided that a series of product-focused dictionaries – representing drugs, appliances and personal medical devices – would be produced. The first of these, the *Primary Care Drug Dictionary*, is being developed under the control of the Prescription Pricing Authority. The UKCPRS project is also overseeing the development of the *Secondary Care and Medical Devices Dictionaries*. The separate elements of UKCPRS will be integrated through the use of SNOMED CT. These are the clinical terms codes that will eventually replace the Read codes.

Why do pharmacists need to use a standard code? Much of the time it takes to process a prescription at the PPA is due to inconsistent or incomplete information printed on a prescription form.

A standard code would enable the PPA to automate the remuneration and reimbursement process while improving the quality of the data captured for the prescribing and dispensing information services it provides to the NHS.

This should be a real benefit to the community pharmacist as it should, in theory, improve the efficiency and speed of the remuneration process.

Healthcare professionals involved in the ETP pilots have found it difficult to relay information about products to the PPA because no standard code is available. Each of the consortia and system suppliers involved have had to invest significant time and resources in matching products from one system to another.

All the pilots match products using "text matching" where the computer finds a drug in its product file with the same name as the product it has received electronically. Clearly this is not the most efficient way of finding a product. If both GPs' and pharmacists' computer systems used the same coding system for products it would be easier and safer to match them.

Electronic health records are beginning to evolve in secondary care. As the health record extends to primary care, a unique product code will be essential so that information about patient medication can be communicated safely and accurately.

In 2000, the Department of Health commissioned the Medicinal Informatics Group at Manchester University to produce a specification of requirements for a *UK Dictionary of Medicinal*

"Where healthcare professionals will be sending product information electronically, there is clearly an even greater need for a standard drugs code"

Products. The latest version of this specification, published in August 2001, formed the starting point for the *UK Primary Care Drug Dictionary* project.

In July 2001 the DoH approved the PPA Drug Reference Business Case for the development of the UKPCDD which identified the following drivers for change from the NHS Plan and the e-Government Strategy:

- forming a cornerstone of electronic prescribing and dispensing (ETP)
- public sector bodies defining and adopting common meanings for common data descriptions (medicines) so that information accessed by public servants or the public can be effectively used and understood
- supporting a framework for departments and agencies to implement electronic record management systems
- providing services which are accessible via the government and other portals
- delivering electronic services and transforming internal processes.

The UKPCDD project team comprises the DoH, NHSIA, The Sowerby Centre for Health Informatics at Newcastle University (SCHIN), RPSGB and the PPA. A full dictionary will be developed and populated by December 2002. An implementation plan for system suppliers is apparently still being developed. There will be no licensing fee for using the data.

Products covered by the UKPCDD are drugs prescribed and reimbursed in primary care, NHS blacklisted products and appliances and reagents listed in the *Drug Tariff*. The dictionary will include the following:

- product name
- product form
- product strength
- route of administration
- price
- legal status
- reimbursement information
- pack information
- ingredient substances including additives
- flavours.

The codes will be used across primary care in the first instance (secondary care is out of scope for the first deliverable dictionary). Although the ETP pilots have already started in England and Scotland, the codes will be used in whatever ETP system is selected for the roll out in England.

The project only covers England and Wales; Scotland and Northern Ireland are not included in the first phase.

GPs and pharmacists will be encouraged to use the codes for electronic patient record management systems and the codes will then help to drive decision support systems across primary care.

It appears that at last a Government-sponsored standard drugs code is being developed. In theory this should improve the efficiency and safety of computer systems across primary healthcare. The project seems to be progressing well in terms of delivering a fully populated database of medicinal products.

How the codes will be implemented and maintained, however, seems a little unclear. It will be no use having a standard product code if computer suppliers do not use it. If these important issues are not addressed, the project could still fail at the final hurdle. The question of how the codes used in primary and secondary care relate to each other also remains unanswered.

Surely a standard drugs code means one which identifies a medical product no matter which sector of healthcare it is used in. If the codes used to identify products in primary and secondary care differ, they are not really standard and they become less useful.

"It will be no use having a standard product code if computer suppliers do not use it"

References

1. Information for Health – An Information Strategy for the Modern NHS – Section 3.21

Julie Hales is a pharmacist with seven years' experience of working in the pharmacy IT industry. She now owns a healthcare consultancy, Future Health Solutions

Are we being led by the nose?

Douglas Simpson says the Royal Pharmaceutical Society is taking liberties with its charter, and commends the YPG plans for its modernisation

The Royal Pharmaceutical Society of Great Britain is the most important pharmacy body in Britain and the way it is managed affects us all. But are we now seeing the end of the Society as we know it?

The answer to that is both "yes" and "no", and being the RPSGB, such questions must be put in context. In order to chart its future, it is important to appreciate its past.

An excellent history has been written by Sydney Holloway. He records that "education, examination, registration and representation" were the watchwords of the Society when it was formed in 1841.

To achieve its objectives the new Society needed to raise standards. Since the regulatory process is designed to provide assured standards of practice in the public interest, the Society has been in the business of regulation from the start, performing that function alongside its representative one.

The 1843 charter provided the legal basis for the first phase of the Society's history. It is the charter plus a number of statutes that prescribe and limit what the Society is able to do. Officials at Lambeth seem to have forgotten this.

The 1843 charter gave the Society's objectives as: "Advancing chemistry and pharmacy and promoting a uniform system of education for those who practise the same and also for the protection of those who carry on the business of chemists and druggists."

The Society must have fulfilled its duties, otherwise the 1933 Pharmacy and Poisons Act, which brought in compulsory membership of the Society for pharmacists, would never have come before Parliament.

The 1933 Act established the Statutory Committee. Says Mr Holloway: "The regulatory and disciplinary functions assigned to the Society in 1933 were not added to the powers of the Council but to a body independent of the Council... by this means the Council was enabled to combine regulatory and individual representational functions."

Two more historical footnotes: the first is the Jenkin judgment. This was all about testing the powers of the Society against the 1843 charter. Mr Holloway says: "It beggars belief that persons involved in the modernisation of the Society should seriously believe that the Jenkin judgement of 1920 prevents the Society from concerning itself with the economics of pharmacy in the 21st century."

Indeed, FW Adams, a former secretary and registrar, maintained that there was nothing in the judgment to prevent the Society from assisting its members to conduct their affairs with financial efficiency.

The final point from this brief historical tour is the supplemental charter of 1953. This updated the original charter to reflect a changing world in which many registered pharmacists were employees. A charter that recognised only proprietors was out of date.

A key alteration was made. The words "the protection of those who carry on the business of chemists and druggists" was changed to "to maintain the honour and safeguard and promote the interests of the members in their exercise of the profession of pharmacy".

So the Pharmaceutical Society became the national body charged with representing the interests of every pharmacist in Great Britain. Nothing has happened since to change the position. Ignore the preaching of the modernisers and look at the charter. That is where the Society's powers are set out.

The chartered objects of the Society have always been its primary objects. The statutory objects have been subordinate. Over the years the Society has taken on new statutory functions and shed others, such as the

control of poisons. But the chartered objects have always continued. They are the bedrock upon which the Society is built.

Why is regulatory reform on the agenda today? The reason is not through any shortcomings in the regulatory processes of pharmacists, but shortcomings in the regulatory processes of the other clinical professions, in particular medicine.

These professions have separate regulatory bodies, unlike pharmacy which uniquely has a professional body that combines regulation with representation. The other health professions have regulatory bodies set up by government, whereas the Society was set up by its members. Arguably, the combined role of regulator and professional association has led to better outcomes than those professions with role separation.

In November 1999 the Department of Health produced a consultation paper on dealing with poor clinical performance among doctors. Called "Supporting doctors, protecting patients", it set out "modern principles of self-regulation in the health field". One key point was that regulatory bodies would be required to have "sufficient lay involvement to make an effective contribution in their governance and operation".

"The Society has been in the business of regulation from the start"

Then we have the NHS Plan in July 2000. This said that the regulation of the clinical professions needed to be strengthened. It said there must be greater public representation on regulatory bodies. It also called for formal co-ordination of regulatory machinery and said that a UK Council of Health Regulators would be established. The Society was one of the bodies mentioned as being covered by the Council.

Pharmacy in the Future said that the Government was looking forward to receiving proposals from the Society to modernise its regulatory procedures. But perhaps the most important document of all is the July 2001 report by Professor Ian Kennedy following the public inquiry into the care of children receiving complex cardiac surgical services at the Bristol Royal Infirmary between 1984 and 1995.

It called for a tightening up of the regulatory processes for all clinical professions. Perhaps its most important contribution was in defining the extent of professional regulation.

Kennedy said: "Professional regulation... encapsulates all of the systems which combine to assure the competence of healthcare professionals: education, registration, training, continuing professional development and revalidation, as well as disciplinary matters."

Kennedy, too, said regulatory bodies "must let the public in to a degree not hitherto contemplated". However, no set level of public membership was suggested.

The Department has broadly accepted its recommendations. It is now legislating to set up the Council for the Regulation of Healthcare Professionals (note the name change) in the NHS Reform and Health Care Professions Bill.

Since then, the Society has been consulting its members before deciding on how to proceed. But it has also been giving the impression that a mindset is developing in Lambeth that sees the Society as first and foremost a regulatory body, with professional representation secondary.

The first indication of this came when the president, Marshall Davies, addressed the British Pharmaceutical Conference in Glasgow last September. The Society's overriding duty must be the public interest, he said. "I want first and foremost to position the pharmacy profession and the Society as dedicated to the public interest."

He went on: "Uniquely, our Society has a role as both a regulator and professional leadership and development body. This confers strengths because it allows us to align professional accountability with professional practice and development. But this does not mean the Society can and should support sectoral

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◀ Continued from page 28

pharmacy interests or particular interests or agendas."

The president said nothing about the Society's representative role. Indeed, his language was that of the regulator, focused on Kennedy to the exclusion of almost everything else.

My view is that the president is not in a position to reposition the Society. He was exceeding his powers when he spoke at the BPC. The Society's powers are defined in the charter and set out under various statutes. The president and the Council are still bound by it.

The second indication that Lambeth is set on a regulatory route came in a debate on code of conduct for Council members. When Council debated the matter last August, it became clear that it had been designed to control Council members' behaviour on the basis that the Society was first and foremost a regulatory body.

Since the beginning of the year there have been a number of articles in the *Pharmaceutical Journal* attempting to set out the Society's stall. On February 2 the president assured us that the Society would continue as a membership organisation, but he does not view this in the same way that the rest of us do.

He suggests that the chartered objective of "maintaining the honour and safeguarding the interests of the members in the exercise of the profession of pharmacy" could form the basis of the modern definition of an effective health regulator. Can it really? All I know is that this clause underpins the Society's role in representing the interests of pharmacists, which is not the same as being a regulator.

I believe that the president's reading is wrong. The wording in the 1953 charter was carefully developed from the 1843 charter wording on "the protection of those carrying on the business of chemists and druggists", which is not a regulatory function.

On February 16 the modernisation steering group published its consultation paper on the remit and functions of the Society. The options were:

1. the status quo
2. retaining the regulatory and professional roles within a reformed Society
3. splitting the regulatory and professional roles, with the Society retaining the professional role
4. splitting the regulatory and professional roles, with the Society retaining the regulatory role
5. merging the Society with other bodies.

Respondents were given until March 28. This was only a few weeks, which must have prejudiced the chance of getting a meaningful response to what is a highly complex issue.

The latest offering from the Society, published in the *PJ* on May 11, is a set of answers to frequently asked questions. One was: "Whom does the Society exist to serve?"

The answer was: "The Society's primary objective is to promote the practice of pharmacy which is in the public interest and, to that purpose, lead, develop and regulate the pharmacy profession. Hence the Society serves the public and serves pharmacists by working with them to help them deliver excellence to patients and the public."

But there is only one sure way of working out whom the Society is there to serve and that is to look at the supplemental charter. That is the only statement that has legitimacy, along with legislation placing requirements on the Society. The Society's answer is the Council's vision statement. It has no legal force.

So what happens next? At the annual general meeting in May we were told that the Council has gone for Option 2, combining professional and regulatory roles in a reformed body. So far, so good. At least it will pre-empt any argument about what should become of the Society's property!

The key thing is the flesh that is put on the bones of that proposal. If it means following Peter Noyce's suggestion that up to half of the Council members should be lay people, that would be quite unacceptable. It might be fit for a regulatory body pure and simple, but it would wreck the Society as a body representing the interests of pharmacists.

What is influencing people is the extent of the regulatory role, as defined by Kennedy. They see it as covering most of the Society's functions. But it depends on how you look at things. The largest group among the Society's staff work not on regulatory matters, but on publishing. Their activities account for 50 per cent of the income of the Society and 35 per cent of its expenditure.

Professional standards and professional development, where most of the regulatory work would lie, accounts for around a quarter of expenditure. So while the Kennedy-inspired list of activities is long, it is more than counterbalanced by another list with publications on it.

Also on the list would be functions associated with representing the interests of pharmacists – the library, the museum (what's left of it), running the branch network and the various conferences.

Then there are the Welsh and Scottish Offices. Since devolution they have become almost totally concerned with representational matters.

To me the only sensible way forward is for the regulatory processes of the Society to be reformed in such a way that the representational role is not compromised. The Young Pharmacist's Group has produced a plan to do this.

Under the plan, a regulation and compliance committee would be set up within the Society's structure. It would deal with the Kennedy agenda, including education and training. The regulation and compliance committee would comprise pharmacy and lay representatives, with pharmacy having a majority by one.

The Council of the Royal Pharmaceutical Society would remain the over-arching body and would continue in its professional representation and leadership role. The vast majority of its members would be pharmacists and none of its officers would be non-pharmacists.

The statutory committee would remain as now but have wider sanctions. Lay participation would be increased. This kind of thing has been done before – in 1933 to be precise – and can be done again.

Indeed, the RPSGB seems to agree with that proposition because it put forward proposals itself only last year to alter the regulatory and disciplinary side of its activities by increasing the amount of lay representation on the Statutory Committee.

These proposals went beyond discipline into the area of professional competence, in line with the Kennedy view. The proposals did not call for an increase in lay representation on the Council itself.

There is, in fact, provision in the byelaws already for the Council to delegate part of its functions to committees comprising lay people, provided that the terms of reference for any such committees are set out in the byelaws. So there would be no need to change the charter.

The YPG solution preserves the Society. I feel that it is something that we can all live with. It needs to be recognised that the Society is not the same as the other bodies regulating health professionals. A means has to be found of adapting the Kennedy agenda to fit the Society's unique position.

"My view is that the president is not in a position to reposition the Society. He was exceeding his powers when he spoke at the BPC"

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Chemist & Druggist's web site – *www.dotpharmacy.co.uk* – has introduced a service that offers pharmacists free legal advice from a leading solicitors' firm.

The service – dotLaw – is being run with the co-operation of Charles Russell, whose specialist legal fields include pharmacy matters.

Pharmacists are advised to e-mail their questions to – *pharmlaw@cmpinformation.com* – along with their full name and the name of their pharmacy. The latter two details are for *C&D*'s records only – pharmacists' identities will be kept anonymous when the answers are published.

All the questions and Charles Russell's replies, which will be available in two working days, will appear on a new dotPharmacy page called dotLaw.

Tax savings strategies

Awards

The Proprietary Association of Great Britain has re-elected **Gavin Bell** as president, **Peter Fry** and **Bron Gorny** as vice presidents and **Clive Dixon** as treasurer. The Royal College of Psychiatrists has elected **Dr Mike Shooter** president. **Dr Andrew Fairbairn** will take over from Dr Shooter as registrar of the College.

MP at Weldrick's awards

Fom left: Sharon Kelly, Kevin Hughes MP, Sarah Everatt, Weldrick's pharmacy training manager Marilyn Jones, and Annette Atkin

Doncaster North MP Kevin North was guest of honour at Hl Weldrick Ltd's annual presentation evening earlier this month. He presented 158 certificates to Weldrick's staff from branches, warehousing and branch support personnel. Besides pharmacy services, warehousing and distribution, retail operations and customer services, achievements in areas such as pain management, oxygen therapy and diabetes counselling were also recognised.

Raising piles for charity

Goodwill has surged recently with people risking a bout of blisters in "awkward" places while fundraising for charity.

Setting their sights, if not their seats, high are an intrepid bunch of cyclists who want to raise £30,000 for Great Ormond Street Hospital by cycling from London to Paris (apart from the wet bit in the middle when they'll use the ferry).

It will be an interesting assortment of cyclists heading off from Trafalgar Square on August 31. There will be representatives from Rowlands Pharmacy, Lloydspharmacy, Phoenix Healthcare, the Co-op, G-Pharma, Profile Ltd, Kimberly Clark and SSL International. Among the non-company participants may well be NPA chief executive John D'Arcy.

Last year a group of nine riders completed the three-day slog to raise £16,000. This year, reaching the Arc de Triomphe could nearly double that. If you would like to help sponsor the group, contact Mike Blakeman, retail projects manager for Rowlands Pharmacy on 01928 754116 or e-mail *mblakeman@rowlandspharmacy.co.uk*.

Meanwhile, a pharmacist father and his 18-year-old daughter are planning a 379-mile cycle trip from St Petersburg to Moscow. To take part in the 70-rider event, David Jeyes, whose pharmacy is in Earls Barton, Northampton and his daughter Anna, have each pledged to raise £2,500 in sponsorship to help the charity Scope.

Anna's interest in taking part in the Russian Bike Away at the end of July stemmed from reading about the event, and from working with teenagers with cerebral palsy during her two years at Northampton College studying health and social care.

Part of the fund-raising activities includes a raffle to be held at the pharmacy on July 13, but David and Anna would appreciate any sponsorship that would benefit Scope.

David is not sure which he will enjoy least, the 50 miles a day the "golden oldie like me" will cycle, or the hostels en route. "Hostels are so rough and ready that camping, even after a hard day's biking, is a sheer joy." He can be contacted on 01604 810289.

With two rides to come, there is news of one that has taken place already. Mandy Kerr, a sales representative for Sankyo's Cetraben Emollient Cream, cycled across parts of Iceland including Reykjavik, Thiungellir and Thjórsà, in the National Eczema Society annual charity bike ride at the beginning of June. Despite wondering whether a decongestant lozenge might have helped, each of the riders earned the charity £2,300.

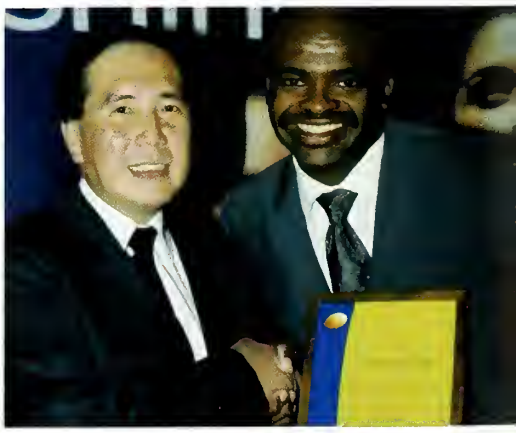
Five go hiking in the dales

The team hope to raise at least £500

United Co-op's pharmacy group will have five members rambling up hill and down dale as they take part in the Yorkshire "Three Peaks Challenge" competing against other sectors of the Co-op family and Sants, the Co-op's pharmaceutical distributors. This Saturday, the teams will stride out on the 25-mile walk in the Yorkshire Dales which will take them to the top of Pen-y-ghent, Ingleborough, and Whernside, the highest of which is 736m. The pharmacy team hopes to raise at least £500 for two hospices – the Donna Louise Trust Children's Hospice in Stoke-on-Trent and the St Ann Hospice, Manchester. Pictured in a pre-challenge practice are (from left) John Nuttall, Nia Evans, supporter Aiden Priestley and Uriah Smith. Taking part in the event but not pictured are Lindsey Fairbrother and Jennifer Cooper.

Champion award for Essex pharmacist

Essex pharmacist Anthony Chong has received an award from Olympic athlete Kriss Akabusi as part of the "Champion of learning awards 2002" organised by the Learning & Skills Council Essex. Anthony, of the People's Pharmacy, Chelmsford, was a winner in the "Helping others to learn" category, after being nominated by Chelmsford Business Link. "Everyone in the room was a winner in the evening, as we had all achieved so much as a result of our dedication to continued learning or contribution to the learning of others," said Anthony.



Anthony Chong receives his award from Kriss Akabusi

Cambridge Counterpart latest winner

Gloria Stocks of the Pelican Pharmacy, Manchester Road, Altrincham, is the winner of this month's Cambridge Counterpart pharmacy assistant training award.

Gloria, an active member of the Baptist Church, was presented with a celebratory bottle of champagne by Wyeth territory manager Ken Grigg and regional manager Dave Petrie, representing the Cambridge Counterpart's sponsors.

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